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AMA Advocacy Resource Center

Physician-led health care teams

Resource materials to support state legislative and regulatory campaigns

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Physician-led health care teams: Identifying the problem and providing a solution

The problem

This country faces a growing health care work force problem. The nation is experiencing shortages of both physicians and nurses. At the same time, there is increasing demand for primary care. There are solutions for addressing these work force shortages and primary care needs, including loan forgiveness programs, increasing the number of residency slots and taking steps to improve reimbursement for primary care services. While these solutions are longer term, there are also steps that can be taken in the short term.

Some have argued that nurse practitioners (NPs)—one type of APRN—should be granted authority to practice independently from physicians as a means to address primary care needs. These arguments come at a time when health care delivery and payment models are heading in the opposite direction. New models of care delivery, including accountable care organizations and patient-centered medical homes, require integration and teamwork among providers to improve health care outcomes and reduce health care costs. A growing number of policy experts recommend these team-based approaches. These two approaches—independent practice and team-based care—take health policy in two very different directions. One approach would further compartmentalize and fragment health care delivery; the other would foster integration and coordination.

The solution

The American Medical Association supports the use of patient-centered, team-based patient care. The AMA believes that increased use of physician-led teams of multidisciplinary health care professionals can have a positive impact on our country's primary care needs. A team-based approach would include physicians and other health professionals working together, sharing decisions and information, for the benefit of the patient. Physicians, NPs, physician assistants, nurses and other professionals would work together, drawing on the specific strengths of each team member.

Health care teams require leadership, just as teams do in business, government, sports and schools. Physicians bring to the team the highest level of training and preparation and as such are the best suited to guide the other members of the team. Nurses are indispensable, but they cannot take the place of a fully trained physician. Physicians are trained to provide complex differential diagnoses, develop a treatment plan that addresses multiple organ systems and order and interpret tests within the context of a patient's overall health condition. The training and education of NPs is appropriate for dealing with patients who need basic, preventive care or treatment of straightforward acute illnesses and previously diagnosed, uncomplicated chronic conditions. NPs and physicians have skills, knowledge and abilities that are not equivalent, but instead are complementary. The most effective way to maximize the talents of the complementary skill sets of both professionals is to work as a team.

We have an opportunity to have a positive effect on the primary care shortage by being more efficient with how primary care is delivered. In short, this country needs more physicians and it needs more nurses, and it needs them working together in teams.

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Patient support for physician-led health care teams

Survey results

New health care delivery system reforms hinge on a team-based approach to care. With their seven years or more of postgraduate education and more than 10,000 hours of clinical experience through acquired training, physicians are uniquely qualified to lead the health care team. Physicians, physician assistants, nurses and other health care professionals have long worked together to meet patient needs for a reason: the physician-led team approach to care works. Patients win when each member of the health care team plays the role they are educated and trained to perform.

2012 and 2018 surveys found that patients overwhelmingly want a coordinated approach to health care, with a physician leading the health care team.[1] Key findings include:

- **Ninety-one percent of respondents said that a physician's years of education and training are vital to optimal patient care, especially in the event of a complication or medical emergency.**
- **Eighty-six percent of respondents said that patients with one or more chronic conditions benefit when a physician leads the primary health care team.**
- **Eighty-four percent of respondents said that they prefer a physician to have primary responsibility for the diagnosis and management of their health care.**

THREE OUT OF FOUR patients prefer to be treated by a physician …

- Even if it takes longer to get an appointment
- Even if it costs more

Do you agree with the following statement?	Yes (%)	No (%)	Not sure (%)	Don't know (%)
Physicians and nurses need to work in a coordinated manner to ensure that patients get the care they need	98	2	0	0
While nurse practitioners are essential to the health care team, they should assist the physician, who should take the lead role in determining the type and level of care to be administered	88	9	2	1
Only physicians have the education and training to look for and diagnose both common and complex medical conditions	83	10	5	2
Nurse practitioners should not be allowed to run their own medical practices without physician involvement	78	19	1	1
Nurse practitioners should not be able to practice independently of physicians, without physician supervision, collaboration or oversight	79	17	3	0
Physicians, rather than nurse practitioners, should diagnose medical conditions	78	16	5	0
Patients benefit when a physician leads the health care team	75	19	3	3

1. Baselice & Associates conducted a telephone survey on behalf of the AMA Scope of Practice Partnership between March 8–12, 2012. Baselice & Associates surveyed 801 adults nationwide. The overall margin of error is +/- 3.5 percent at the 95 percent level; Baselice & Associates conducted an internet survey of 801 adults on behalf of the AMA Scope of Practice Partnership between May 1–June 6, 2014. The overall margin of error is +/- 3.5 percent at the 95 percent confidence level.

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Should only a medical doctor or doctor of osteopathic medicine be allowed to perform the following procedures or should other health care professionals be allowed to perform this specific activity?	Only a medical doctor (%)	Other health care professional (%)	Both equally/ either one (%)	Don't know (%)
Amputations of the foot?	92	5	2	2
Diagnose and treat heart conditions?	92	4	3	1
Surgical procedures on the eye that require the use of a scalpel?	90	5	2	3
Treat emergency or traumatic medical conditions, which may be life threatening?	90	4	5	1
Facial surgery such as nose shaping and face lifts?	87	7	3	6
Write prescriptions for complex drugs, including those that carry risk of abuse or dependence?	83	10	5	2
Administer and monitor anesthesia levels and patient condition before and during surgery?	78	15	6	1
Diagnose and treat chronic diseases like diabetes	78	15	6	1
Write prescriptions for medication to treat mental health conditions such as schizophrenia and bi-polar disorder?	77	11	6	4

Frequently asked questions

Don't most health care professionals already work in teams?

Team-based practice is certainly the norm rather than the exception. Physicians, physician assistants, nurse practitioners (NPs), registered nurses, licensed practical nurses, patient care associates, patient advocates (PAs), social workers and mental health specialists, along with registration and administrative personnel, are physicians' regular companions. Not to mention pharmacists, radiology teams, and hospital staffs of physician specialists and technicians. All members of the team have roles to play, and those roles are regularly played in harmony.

New models of care delivery, including accountable care organizations and patient-centered medical homes, require integration and teamwork among providers to improve health care outcomes and reduce health care costs. A growing number of policy experts recommend these team-based approaches over solo and independent practice by physicians, nurses and other providers. Much-heralded places like the Mayo Clinic, the Geisinger Health Center in Pennsylvania, and Intermountain Healthcare provide examples of team medical practices that have been successful over many years. Though physician-led, team-based medicine appears to be the way of the future, a great deal must happen for it to succeed.

The American Medical Association supports the use of patient-centered, team-based patient care. The AMA believes that the best model has physicians in the lead, with care provided by all professionals performing up to their level of training, at the discretion of the physician leader. In this arrangement, the person patients say they want in charge of their care—the physician—is in that position, but the strengths and perspectives of all professions in the health care team are utilized to provide the safest, best treatment.

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What are the key elements of this campaign?

The physician-led team campaign defines a "patient care team" as a multidisciplinary team of health care providers actively functioning as a unit with the management and leadership of the team handled by one or more patient care team physicians for the purposes of providing health care to a patient or group of patients. The physician-led health care team campaign establishes NPs as part of a physician-led patient care team. Within these teams each member has specific responsibilities related to the care of the patient or patients and shall provide health care services within the scope of his or her usual professional activities. The campaign also allows for NPs practicing as part of a physician-led patient care team to maintain appropriate collaboration and consultation with at least one patient care teamj physician. The campaign also establishes a process through which NPs gain the authority to prescribe certain controlled substances and a framework for joint regulation of nurse practitioners by the state boards of medicine and nursing.

Why is the AMA pushing this legislation now?

Improving the nation's health care system requires taking many issues into account. This country faces a growing health care work force problem. The nation is experiencing shortages of both physicians and nurses. At the same time, there is increasing demand for primary care. According to a 2010 analysis by the Association of American Medical Colleges, the shortage of physicians—defined as how many physicians the country is lacking given patient demand—is expected to be 130,600 by 2025, while the number of job openings for nurses due to growth and replacements to will total 1.2 million by 2020.

There are solutions for addressing these work force shortages and primary care needs, including loan forgiveness programs, increasing the number of residency slots and taking steps to improve reimbursement for primary care services. While these solutions are longer term, there are also steps that can be taken in the short term. The AMA believes that increased use of physician-led teams of multidisciplinary health care professionals can have a positive impact on our country's primary care needs. We have to take this opportunity to make a serious dent in the primary care shortage by being more efficient about how primary care is delivered.

Is this campaign an attempt to restrict the practice of non-physicians?

Quite the opposite is true. This campaign provides health care teams the flexibility to allow the team's members to practice to their full capacity. The AMA believes that increased use of physician-led teams of multidisciplinary health care professionals can have a positive impact on our country's primary care needs. A team-based approach would include physicians and other health professionals working together, sharing decisions and information, for the benefit of the patient. Physicians, NPs, PAs, nurses and other professionals would work together, drawing on the specific strengths of each member. This country needs more physicians and it needs more nurses, and it needs them working together in teams. Physician-led, team-based medical practice offers promise for our American health care system—a system that provides the most effective, efficient and cost-effective care for our growing patient population.

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Why should physicians lead the team?

Health care teams require leadership, just as teams do in business, government, sports and schools. Physicians bring to the team the highest level of training and preparation and, as such, are the best suited to guide the other members of the team. Nurses are indispensable, but they cannot take the place of a fully trained physician. Physicians are trained to provide complex differential diagnoses, develop a treatment plan that addresses multiple organ systems and order and interpret tests within the context of a patient's overall health condition. The training and education of NPs is appropriate for dealing with patients who need basic, preventive care or treatment of straightforward acute illnesses and previously diagnosed, uncomplicated chronic conditions. NPs and physicians have skills, knowledge and abilities that are not equivalent, but instead are complementary. The most effective way to maximize the talents of the complementary skill sets of both professionals is to work as a team.

Is this what patients want?

Patients understand the need for team-based care—but if there is collaboration, they want to know a physician is taking the lead. An AMA survey of patients, released in 2012, found 98 percent saying physicians and nurses need to work in a coordinated matter to ensure patients get the care they need. Meanwhile, large majorities—upward of 75 percent—said they wanted physicians in charge of diagnosing complex and common medical conditions, and that physicians should provide supervision for other health professionals. Three out of four patients agreed with the statement, "Patients benefit when a physician leads the health care team."

Who did your survey and what methodology was used?

Baselice & Associates conducted a survey on behalf of the AMA Scope of Practice Partnership between March 8–12, 2012. Baselice & Associates surveyed 801 adults nationwide. The overall margin of error is +/- 3.5 percent at the 95 percent level.

Baselice & Associates conducted an internet survey of 801 adults on behalf of the AMA Scope of Practice Partnership between May 1–June 6, 2014. The overall margin of error is +/- 3.5 percent at the 95 percent confidence level.

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Model legislation

IN THE GENERAL ASSEMBLY STATE OF___________

An Act to Support Physician-Led Team Based Health Care

1 Be it enactedby the People of the State of______________________, represented in the General
2 Assembly:
3 **Section 1. Title.** This act shall be known as and may be cited as the Team Based Health Care
4 Act.
5 **Section 2. Purpose.** The Legislature hereby finds and declares that:
6 A. The ongoing success of integrated health care systems can be attributed to the
7 physician leadership within organizational and administrative aspects of their respective health
8 care system.
9 B. Increased use of physician-led health care teams has the potential to offset
10 completely the increase in demand for physician services while improving access to care, thereby
11 averting a primary care physician shortage.
12 C. According to survey data, a vast majority of patients believe that patients with one
13 or more chronic conditions benefit when a physician leads the primary health care team.
14 D. Four out of five patients prefer a physician to have primary responsibility for
15 leading and coordinating their health care.
16 E. Advanced Practice Registered Nurses (APRNs) are increasingly engaged in what
17 has traditionally been considered the practice of medicine.
18 F. Team-based care is essential to protect and maintain the public health and safety.

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1 **Section 3. Definitions**.

2 A. "Patient care team" means a multidisciplinary team of health care providers actively
3 functioning as a unit with the management and leadership of one or more patient care team physicians
4 for the purposes of providing and delivering health care to a patient or group of
5 patients.

6 B. "Patient care team physician" means a physician who is actively licensed to practice
7 medicine in the State of ________________, who regularly practice medicine in the State of
8 ________________, and who provides management and leadership in the care of all patients as part of a
9 patient care team.

10 C. "Collaboration" means the communication and decision-making process among
11 members of a physician-led patient care team related to the treatment and care of a patient and
12 includes (i) communication of data and information about the treatment and care of a patient,
13 including exchange of clinical observations and assessments; and (ii) development of an
14 appropriate plan of care, including decisions regarding the health care provided, accessing and
15 assessment of appropriate additional resources or expertise, and arrangement of appropriate
16 referrals, testing, or studies.

17 D. "Consultation" means a process whereby an APRNseeks the advice or opinion of a
18 physician or another health care practitioner.

19 E. "Advanced Practice Registered Nurse" or "APRN" means a registered nurse (RN)
20 who:

21 1. Who has completed an accredited graduate-level education program preparing
22 him/her for one of the four recognized APRN roles;

23 2. Who has passed a national certification examination that measures APRN, role
24 and population-focused competencies and who maintains continued competence as

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1 evidenced by recertification in the role and population through the national certification
2 program;
3 3. Who has acquired advanced clinical knowledge and skills preparing him/her to
4 provide direct care to patients, as well as a component of indirect care; however, the
5 defining factor for all APRNs is that a significant component of the education and
6 practice focuses on direct care of individuals;
7 4. Whose practice builds on the competencies of RNs by demonstrating a greater
8 depth and breadth of knowledge, a greater synthesis of data, increased complexity of
9 skills and interventions, and greater role autonomy within the patient care team;
10 5. Who is educationally prepared to assume responsibility and accountability
11 within the patient care team for health promotion and/or maintenance as well as the
12 assessment, diagnosis, and management of patient problems, which includes the use and
13 prescription of pharmacologic and non-pharmacologic interventions;
14 6. Who has clinical experience of sufficient depth and breadth to reflect the
15 intended license; and
16 7. Who is jointly licensed by the Board of Medicine and the Board of Nursing to
17 practice as an APRN in one of the four APRN roles: certified registered nurse anesthetist
18 (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS), or certified
19 nurse practitioner (CNP) pursuant to Section 4.
20 **Section 4. Requirements – Licensure and practice of APRNs**.
21 A. The Board of Medicine and the Board of Nursing shall jointly prescribe the
22 regulations governing the licensure of APRNs. It shall be unlawful for a person to practice as an
23 APRN in [state] unless he holds such a joint license.
24

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1 B. As provided in Section G, an APRN shall only practice as part of a physician-
2 ledpatient care team. Each member of a physician-led patient care team shall have specific
3 responsibilities related to the care of the patient or patients and shall provide health care services
4 within the scope of his usual professional activities. APRNs practicing as part of a physician-led
5 patient care team shall maintain appropriate collaboration and consultation, as evidenced in a
6 written or electronic practice agreement, with at least one patient care team physician. APRNs
7 who are CRNAs shall practice under the supervision of a licensed doctor of medicine, doctor of
8 osteopathic medicine, podiatry, or dentistry. Collaboration and consultation among APRNs and
9 patient care team physicians may be provided through telemedicine as described in [telemedicine act].
10 Practice of patient care teams in all settings shall include the periodic review of patient
11 charts or electronic health records and may include visits to the site where health care is
12 delivered in the manner and at the frequency determined by the physician-led patient care team.
13 C. The Board of Medicine and the Board of Nursing shall jointly promulgate regulations
14 specifying collaboration and consultation among physicians and APRNs working as part of
15 physician-led patient care teams that shall include the development of, and periodic review and
16 revision of, a written or electronic practice agreement; guidelines for availability and ongoing
17 communications that define consultation among the collaborating parties and the patient; and
18 periodic joint evaluation of the services delivered. Practice agreements shall include a provision
19 for appropriate physician input wherever needed, such as in complex clinical cases and patient
20 emergencies and for referrals. Evidence of a practice agreement shall be maintained by an APRN
21 and provided to the Boards. For APRNs providing care to patients within a hospital or health
22 care system, the practice agreement may be included as part of documents delineating the
23 APRN's clinical privileges or the electronic or written delineation of duties and responsibilities
24 in collaboration and consultation with a patient care team physician.

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1 D. The Board of Medicine and the Board of Nursing may jointly issue a license by
2 endorsement to an applicant to practice as an APRN if the applicant has been licensed as an
3 APRN under the laws of another state and, in the opinion of the Board of Medicine and the
4 Board of Nursing, the applicant meets the qualifications for licensure required of APRNs in
5 Section _____________.
6 E. Physicians on physician-led patient care teams may require that an APRN be covered
7 by a professional liability insurance policy with limits equal to the current limitation on damages
8 set forth in Section _____________. Service on a patient care team by a physician-led patient care
9 team member shall not, by the existence of such service alone, establish or create liability for the
10 actions or inactions of other team members.
11 F. Physicians shall not serve as a physician-led patient care team physician on a patient
12 care team at any one time to more than ___ APRN.
13 G. The APRN shall disclose to the patient at the initial encounter that he or she is a
14 licensed certified registered nurse anesthetist, certified nurse-midwife, clinical nurse specialist,
15 or certified nurse practitioner. Any member of a physician-led patient care team shall disclose,
16 upon request of a patient or his legal representative, the name of the physician-led patient care
17 team physician and information regarding how to contact the patient care team physician.
18 H. In the event a physician who is serving as a patient team physician dies, becomes
19 disabled, retires from active practice, surrenders his license or has it suspended or revoked by the
20 Board, or relocates his practice such that he is no longer able to serve, and an APRN is unable to
21 enter into a new practice agreement with another patient care team physician, the APRN may continue
22 to practice upon notification to the designee or his alternate of the Boards and receipt of such
23 notification. Such APRN may continue to treat patients without a patient care team
24 physician for an annual period not to exceed 60 days, provided the APRN continues to prescribe

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1 only those drugs previously authorized by the practice agreement with such physician and to
2 have access to appropriate physician input in complex clinical cases and patient emergencies and
3 for referrals. The designee or his alternate of the Boards shall grant permission for the APRN to
4 continue practice under this subsection for another 60 days, provided the APRN provides
5 evidence of efforts to secure another patient care team physician and access to physician input.
6
7 **<u>Section 5. Prescriptive Authority</u>**
8 A. In accordance with the provisions of this section and pursuant to the requirements of
9 Section ____________, an APRN shall have the authority to prescribe Schedule __ through
10 Schedule __ controlled substances and devices as set forth in Section ____________. APRNs
11 shall have such prescriptive authority upon the provision to the Board of Medicine and the Board
12 of Nursing of such evidence as they may jointly require that the APRN has entered into and is, at
13 the time of writing a prescription, a party to a written or electronic practice agreement with a
14 physician-led patient care team physician that clearly states the prescriptive practices of the
15 APRN. Such written or electronic practice agreements shall include the controlled substances the
16 APRN is or is not authorized to prescribe and may restrict such prescriptive authority as
17 described in the practice agreement. Evidence of a practice agreement shall be maintained by an
18 APRN.. Practice agreements authorizing an APRN to prescribe controlled substances or devices
19 pursuant to this section shall either be signed by the patient care team physician who is practicing
20 as part of a patient care team with the APRN or shall clearly state the name of the patient care
21 team physician who has entered into the practice agreement with the APRN.
22 *[Drafting note: A state may wish to differentiate prescriptive authority based on category*
23 *of APRN. For example, in many states CRNAs and CNMs do not have prescriptive authority.]*

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1 B. It shall be unlawful for an APRN to prescribe controlled substances or devices
2 pursuant to this section unless such prescription is authorized by the written or electronic
3 practice agreement.
4 C. The Board of Nursing and the Board of Medicine shall promulgate such regulations
5 governing the prescriptive authority of APRNs as are deemed reasonable and necessary to ensure
6 an appropriate standard of care for patients. Regulations promulgated pursuant to this section
7 shall include, at a minimum, such requirements as may be necessary to ensure continued
8 APRNcompetency, which may include continuing education, testing, or any other requirement,
9 and shall address the need to promote ethical practice, an appropriate standard of care, patient
10 safety, the use of new pharmaceuticals, and appropriate communication with patients.
11 D. This section shall not limit the functions and procedures of APRNs which are
12 otherwise authorized by law or regulation.
13 E. This section shall not prohibit a licensed nurse practitioner from administering
14 controlled substances in compliance with the definition of "administer" in Section ____________
15 or from receiving and dispensing manufacturers' professional samples of controlled substances
16 in compliance with the provisions of this section.
17 **Section 5. Effective.** This Act shall become effective immediately upon being enacted into law.
18 **Section 6. Severability.** If any provision of this Act is held by a court to be invalid, such
19 invalidity shall not affect the remaining provisions of this Act, and to this end the provisions of
20 this Act are hereby declared severable.
21 Adopted 2013; revised February 2018

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IN THE GENERAL ASSEMBLY STATE OF___________

An Act to Support Joint Regulation of Advanced Practice Registered Nurses

1 Be it enacted by the People of the State of_________________, represented in the General

2 Assembly:

3 **Section 1. Title.** This act shall be known as the Joint Regulation of APRNs Act.

4 **Section 2. Purpose.** The Legislature hereby finds and declares that:

5 A. Advanced Practice Registered Nurses (APRNs) are increasingly engaged in what has

6 traditionally been considered the practice of medicine.

7 B. Joint regulation of APRNs is essential to protect and maintain the public health and

8 safety.

9 **Section 3. Definitions**.

10 A. "Advanced Practice Registered Nurse" or "APRN" means a registered nurse (RN)

11 who is jointly licensed by the Board of Medicine and the Board of Nursing to practice as an

12 APRN in one of the four APRN roles: certified registered nurse anesthetist (CRNA), certified

13 nurse-midwife (CNM), clinical nurse specialist (CNS), or certified nurse practitioner (CNP).

14 **Section 4. Requirements – Licensure and practice of APRNs.**

15 A. The Board of Medicine and the Board of Nursing shall jointly prescribe the regulations

16 governing the licensure of APRNs. It shall be unlawful for a person to practice as an APRN in [state]

17 unless he holds such a joint license.

18 B. The Board of Medicine and the Board of Nursing shall jointly promulgate regulations

19 specifying collaboration and consultation among physicians and APRNs working as part of

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1 physician-led patient care teams that shall include the development of, and periodic review and
2 revision of, a written or electronic practice agreement; guidelines for availability and ongoing
3 communications that define consultation among the collaborating parties and the patient; and
4 periodic joint evaluation of the services delivered. Practice agreements shall include a provision
5 for appropriate physician input wherever needed, such as in complex clinical cases and patient
6 emergencies and for referrals. Evidence of a practice agreement shall be maintained by an APRN
7 and provided to the Boards. For APRNs providing care to patients within a hospital or health
8 care system, the practice agreement may be included as part of documents delineating the
9 APRN's clinical privileges or the electronic or written delineation of duties and responsibilities
10 in collaboration and consultation with a patient care team physician.
11 C. The Board of Medicine and the Board of Nursing may jointly issue a license by
12 endorsement to an applicant to practice as an APRN if the applicant has been licensed as an
13 APRN under the laws of another state and, in the opinion of the Board of Medicine and the
14 Board of Nursing, the applicant meets the qualifications for licensure required of APRNs
15 *[Drafting Note: See Appendix for sample language that can be used in drafting or*
16 *modifying regulations governing the licensure of APRNs pursuant to this section.]*
17 **Section 5. Prescriptive Authority**
18 A. In accordance with the provisions of this section and pursuant to the requirements of Section
19 ____________, an APRN shall have the authority to prescribe Schedule __ through
20 Schedule __ controlled substances and devices as set forth in Section ____________. APRNs
21 shall have such prescriptive authority upon the provision to the Board of Medicine and the Board
22 of Nursing of such evidence as they may jointly require that the APRN has entered into and is, at
23 the time of writing a prescription, a party to a written or electronic practice agreement with a
24 physician-led patient care team physician that clearly states the prescriptive practices of the

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1 APRN. Such written or electronic practice agreements shall include the controlled substances the
2 APRN is or is not authorized to prescribe and may restrict such prescriptive authority as
3 described in the practice agreement. Evidence of a practice agreement shall be maintained by an
4 APRN. Practice agreements authorizing an APRN to prescribe controlled substances or devices
5 pursuant to this section shall either be signed by the patient care team physician who is practicing
6 as part of a patient care team with the APRN or shall clearly state the name of the patient care
7 team physician who has entered into the practice agreement with the APRN.
8 *[Drafting note: A state may wish to differentiate prescriptive authority based on category*
9 *of APRN. For example, in many states CRNAs and CNMs do not have prescriptive authority.]*
10 B. It shall be unlawful for an APRN to prescribe controlled substances or devices
11 pursuant to this section unless such prescription is authorized by the written or electronic
12 practice agreement.
13 C. The Board of Nursing and the Board of Medicine shall promulgate such regulations
14 governing the prescriptive authority of APRNs as are deemed reasonable and necessary to ensure
15 an appropriate standard of care for patients. Regulations promulgated pursuant to this section
16 shall include, at a minimum, such requirements as may be necessary to ensure continued APRN
17 competency, which may include continuing education, testing, or any other requirement, and
18 shall address the need to promote ethical practice, an appropriate standard of care, patient safety,
19 the use of new pharmaceuticals, and appropriate communication with patients.
20 *[Drafting Note: See Appendix for sample language that can be used in drafting or modifying*
21 *regulations governing the prescriptive authority of APRNs pursuant to this section.]*
22 D. This section shall not limit the functions and procedures of APRNs which are
23 otherwise authorized by law or regulation.

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1 E. This section shall not prohibit an APRN from administering controlled substances in

2 compliance with the definition of "administer" in Section ___________ or from receiving and

3 dispensing manufacturers' professional samples of controlled substances in compliance with the

4 provisions of this section.

5 **Section 5. Effective.** This Act shall become effective immediately upon being enacted into law.

6 **Section 6. Severability.** If any provision of this Act is held by a court to be invalid, such

7 invalidity shall not affect the remaining provisions of this Act, and to this end the provisions of

8 this Act are hereby declared severable.

9 Adopted February 2018

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Appendix – Examples of regulatory language for the joint regulation of APRNs

[Note: States may wish to utilize existing APRN or Nursing Practice Act provisions on such topics as licensure requirements, fees, competency requirements, and qualifications for prescriptive authority.]

Definitions.

The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Advanced Practice Registered Nurse" or "APRN" means a registered nurse (RN) who is jointly licensed by the Board of Medicine and the Board of Nursing to practice as an APRN in one of the four APRN roles: certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS), or certified nurse practitioner (CNP) pursuant to [model bill].

"Boards" means the Board of Nursing and the Board of Medicine.

"Certified nurse midwife" or "CNM" means an APRN who is certified in the role of nurse midwife and who is jointly licensed by the Boards of Medicine and Nursing as a CNM pursuant to [model bill].

"Certified nurse practitioner" or "CNP" means an APRN who is certified in the role of of nurse practitioner and who is jointly licensed by the Boards of Medicine and Nursing as a CNM pursuant to [model bill].

"Certified registered nurse anesthetist" or "CRNA" means an APRN who is certified in the role of nurse anesthetist, who is jointly licensed by the Boards of Medicine and Nursing as a CRNA pursuant to [model bill], and who practices under the supervision of a doctor of medicine, osteopathic medicine, podiatry, or dentistry but is not subject to the practice agreement requirement described in [model bill].

"Committee" means the Committee of the Joint Boards of Nursing and Medicine.

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"Practice agreement" means a written or electronic statement, jointly developed by the collaborating patient care team physician(s) and the APRN(s) that describes the procedures to be followed and the acts appropriate to the specialty practice area to be performed by the APRN(s) in the care and management of patients. The practice agreement also describes the prescriptive authority of the APRN, if applicable.

Committee of the Joint Boards of Nursing and Medicine.

A. The chairs of the Boards of Nursing and Medicine respectively shall each appoint three members from their boards to the Committee of the Joint Boards of Nursing and Medicine. The purpose of this committee shall be to administer the Regulations governing the licensure of APRNs.

B. The committee, in its discretion, may appoint an advisory committee. Such an advisory committee shall be comprised of four licensed physicians and four licensed APRNs, of whom one shall be a certified nurse midwife, one shall be a certified registered nurse anesthetist and two shall be nurse practitioners. Appointment to the advisory committee shall be for four years; members may be appointed for one additional four-year period.

Practice of certified nurse practitioners.

A. A CNP shall be authorized to render care in collaboration and consultation with a licensed patient care team physician as part of a patient care team.

B. The practice shall be based on specialty education preparation as an APRN in accordance with standards of the applicable certifying organization, as identified in ___________.

C. All CNPs shall practice in accordance with a written or electronic practice agreement as defined in ___________.

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D. The written or electronic practice agreement shall include provisions for:

1. The periodic review of patient charts or electronic patient records by a patient care team physician and may include provisions for visits to the site where health care is delivered in the manner and at the frequency determined by the patient care team;

2. Appropriate physician input in complex clinical cases and patient emergencies and for referrals; and

3. The CNP's authority for signatures, certifications, stamps, verifications, affidavits, and endorsements provided it is:

a. In accordance with the specialty license of the CNP and within the scope of practice of the patient care team physician;

b. Permitted by [model bill] or applicable sections of the Code of [State]; and

c. Not in conflict with federal law or regulation.

E. The practice agreement shall be maintained by the CNP and provided to the boards. For CNPs providing care to patients within a hospital or health care system, the practice agreement may be included as part of documents delineating the CNP's clinical privileges or the electronic or written delineation of duties and responsibilities; however, the CNP shall be responsible for providing a copy to the boards.

Practice of certified registered nurse anesthetists.

A. A CRNA shall be authorized to render care under the supervision of a licensed doctor of medicine, osteopathic medicine, podiatry, or dentistry.

B. The practice of a CRNA shall be based on specialty education preparation as an APRN

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in accordance with standards of the applicable certifying organization and with the functions and standards defined by the American Association of Nurse Anesthetists (Standards for Nurse Anesthesia Practice, Revised 2013).

Practice of certified nurse midwives.

A. A CNM shall practice in consultation with a licensed physician in accordance with a practice agreement between the CNM and the physician. Such practice agreement shall address the availability of the physician for routine and urgent consultation on patient care.

B. The practice agreement shall be maintained by the CNM and provided to the boards. For nurse midwives providing care to patients within a hospital or health care system, the practice agreement may be included as part of documents delineating the CNM's clinical privileges or the electronic or written delineation of duties and responsibilities; however, the CNM shall be responsible for providing a copy to the boards.

C. An APRN licensed in the category of a CNM shall practice in accordance with the Standards for the Practice of Midwifery (Revised 2011) defined by the American College of Nurse-Midwives.

Hearings.

A. The provisions of the [administrative procedures act] shall govern proceedings on questions of violation of ___________.

B. The Committee of the Joint Boards of Nursing and Medicine shall conduct all proceedings prescribed herein and shall take action on behalf of the boards.

C. When a person's license to practice nursing has been suspended or revoked by the Board of Nursing, the APRN license shall be suspended pending a hearing simultaneously with the institution of

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proceedings for a hearing.

D. Sanctions or other terms and conditions imposed by consent orders entered by the Board of Nursing on the license to practice nursing may apply to the APRN license, provided the consent order has been accepted by the Committee of the Joint Boards of Nursing and Medicine.

Delegation of proceedings.

A. Decision to delegate. The Joint Boards of Nursing and Medicine (committee) may delegate an informal fact-finding proceeding to an agency subordinate upon determination that probable cause exists that an APRN may be subject to a disciplinary action.

B. Criteria for delegation. Cases that involve intentional or negligent conduct that caused serious injury or harm to a patient may not be delegated to an agency subordinate, except as may be approved by the chair of the committee.

C. Criteria for an agency subordinate.

1. An agency subordinate authorized by the committee to conduct an informal fact-finding proceeding may include current or past board members and professional staff or other persons deemed knowledgeable by virtue of their training and experience in administrative proceedings involving the regulation and discipline of health professionals.

2. The Executive Director of the Board of Nursing shall maintain a list of appropriately qualified persons to whom an informal fact-finding proceeding may be delegated.

3. The committee may delegate to the executive director the selection of the agency subordinate who is deemed appropriately qualified to conduct a proceeding based on the qualifications of the subordinate and the type of case being heard.

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Authority and administration of regulations for prescriptive authority.

A. The statutory authority for this chapter is found in [model bill].

B. Joint boards of nursing and medicine.

1. The Committee of the Joint Boards of Nursing and Medicine shall be appointed to administer this chapter governing prescriptive authority.

2. The boards hereby delegate to the Executive Director of the Board of Nursing the authority to issue the initial authorization and biennial renewal to those persons who meet the requirements set forth in this chapter and to grant extensions or exemptions for compliance with continuing competency requirements as set forth in ___________. Questions of eligibility shall be referred to the committee.

3. All records and files related to prescriptive authority for APRNs shall be maintained in the office of the Board of Nursing.

Authority to prescribe, general.

A. No licensed APRN shall have authority to prescribe certain controlled substances and devices in the [State] except in accordance with this chapter and as authorized by the boards.

B. The boards shall approve prescriptive authority for applicants who meet the qualifications set forth in ___________ of this chapter.

Practice agreement for prescriptive authority.

A. With the exception of subsection E of this section, An APRN with prescriptive authority may prescribe only within the scope of the written or electronic practice agreement with a patient care team physician.

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B. At any time there are changes in the patient care team physician, authorization to prescribe, or scope of practice, the APRN shall revise the practice agreement and maintain the revised agreement.

C. The practice agreement shall contain the following:

1. A description of the prescriptive authority of the APRN within the scope allowed by law and the practice of the APRN.

2. An authorization for categories of drugs and devices within the requirements of [model bill].

3. The signature of the patient care team physician who is practicing with the APRN or a clear statement of the name of the patient care team physician who has entered into the practice agreement.

D. In accordance with [model bill], a physician shall not serve as a patient care team physician to more than __ APRNs with prescriptive authority at any one time.

E. An APRN licensed in the category of CNM and holding a license for prescriptive authority may prescribe in accordance with a written or electronic practice agreement with a consulting physician or may prescribe Schedule VI controlled substances without the requirement for inclusion of such prescriptive authority in a practice agreement.

F. An APRN licensed in the category of CRNA and holding a license for prescriptive authority may prescribe in accordance with a written or electronic supervisory agreement with a consulting physician or may prescribe Schedule VI controlled substances without the requirement for inclusion of such prescriptive authority in a practice agreement.

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Grounds for disciplinary action.

A. The boards may deny approval of prescriptive authority, revoke or suspend authorization, or take other disciplinary actions against an APRN who:

1. Exceeds his authority to prescribe or prescribes outside of the written or electronic practice agreement with the patient care team physician or, for CNMs, the practice agreement with the consulting physician, or, for CRNAs, the supervisory agreement with the supervising physician;

2. Has had his license as an APRN suspended, revoked or otherwise disciplined by the boards pursuant to ___________;

3. Fails to comply with requirements for continuing competency as set forth in ___________.

B. Unauthorized use or disclosure of confidential information received from the Prescription Monitoring Program shall be grounds for disciplinary action.

Administrative proceedings.

A. Except as provided for delegation of proceedings to an agency subordinate in [state administrative procedures act], the Committee of the Joint Boards of Nursing and Medicine shall conduct all hearings prescribed herein and shall take action on behalf of the boards.

B. The APRN with prescriptive authority shall be subjective to the grounds for disciplinary action set forth in ___________.

C. When the license of an APRN has been suspended or revoked by the joint boards, prescriptive authority shall be suspended pending a hearing simultaneously with the institution of proceedings for a hearing.

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D. Any violation of law or of this chapter may result in disciplinary action including the revocation or suspension of prescriptive authority and may also result in additional sanctions imposed on the license of the APRN by the joint boards or upon the license of the registered nurse by the Board of Nursing.

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State bill summaries

Virginia House Bill 346

Background

Physician organizations and nurse practitioner (NP) organizations often find themselves on opposing sides of legislative scope of practice battles. But in Virginia both sides worked together to craft a law that outlines how they will partner to provide team-based care. The Medical Society of Virginia and Virginia Council Nurse Practitioners collaborated for nearly two years to explore solutions that address systematic challenges to access to care. Virginia House Bill 346 (HB 346) was the product of this two-year dialogue. The bill was signed into law (Chapter 213) on March 10, 2012.

Definitions

Collaboration

The communication and decision-making process among members of the patient care team related to the treatment and care of a patient, including: (i) communication of data and information about the treatment and care of a patient, including clinical observations and assessments, and (ii) development of an appropriate plan of care, including decisions regarding the health care provided, accessing and assessment of appropriate additional resources or expertise, and arrangement of appropriate referrals, testing or studies.

Consultation

The communicating of data and information, exchanging of clinical observations and assessments, accessing and assessing of additional resources and expertise, problem-solving and arranging for referrals, testing or studies.

Patient care team

A multidisciplinary team of health care providers actively functioning as a unit with the management and leadership of one or more patient care team physicians for the purpose of providing and delivering care to a patient or group of patients.

Patient care team physician

A physician actively licensed to practice medicine in Virginia who provides management and leadership in the care of patients as part of a patient care team.

Other

The law supports consultation and collaboration among physicians and NPs while preserving physician leadership and management of patient care teams. Specific provisions include:

- Nurse practitioners must practice as part of a patient care team, which includes maintaining appropriate collaboration and consultation with at least one patient care team physician.

- Prescriptive authority—the law grants nurse practitioners the authority to prescribe Schedule II through Schedule VI controlled substances and devices, pursuant to a practice agreement with a physician that clearly states the nurse practitioner's prescriptive authority.

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- This collaboration and consultation can take place through telemedicine, allowing NPs to work in locations separate from their team physician (e.g., nursing homes, free clinics in medically underserved areas). Before enactment of the law, NPs had to work under direct supervision of a physician in the same location.

- For NPs providing care to patients within a hospital or health care system, the requirement for a practice agreement may be satisfied by evidence of the credentialing document for that NP working in the hospital or health care system.

- Each member of the patient care team must have specific responsibilities related to the care of the patient(s).

- The law expands to six the number of NPs a physician can partner with. Before enactment of the law, physicians could partner with only four NPs.

- Practice agreements can be submitted electronically. Before the law, practice agreements had to be maintained in paper form.

Texas Senate Bill 406

With AMA support, resources, and counsel, the Texas Medical Association reached an agreement with nurse practitioners (NPs) and physician assistants (PAs) on a model of physician-led, team-based care. The bill—S.B. 406—changes Texas statutes governing physician delegation and supervision of prescribing authority to NPs and PAs. Passage of S.B. 406 makes Texas the second state to enact legislation directly in support of physician-led health care teams, following landmark Virginia legislation in 2012. The bill was signed June 14, 2013 and went into effect November 1, 2013.

Bill provisions

- Senate Bill 406 establishes a delegated and supervised model of physician practice with NPs and PAs. Independent diagnosing and prescribing are the practice of medicine. A physician can delegate but must supervise, and retains accountability.

- The numbers of NPs and PAs that a physician may supervise increased to a total of seven, or their FTEs, without a waiver from the Texas Board of Medical Examiners (previously required for more than four supervisees).

- Physicians may delegate to a NP or PA, acting under adequate physician supervision, the act of prescribing or ordering a drug or device as authorized through a prescriptive authority agreement between the physician and the NP or PA. Though S.B. 406 spends considerable time outlining the required provisions of such an agreement, the physician can modify the prescriptive authority agreement as he/she sees fit.

    — The bill allows a physician to delegate the prescribing or ordering of a Schedule II controlled substance only in a hospital facility-based practice, or as part of the plan of care for the treatment of a hospice patient.

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- Physicians will be required to sign a prescriptive authority agreement and document quality improvement meetings.

- The site based proxies for quality assurance – time on site variations, mileage limitations, mandated numbers of chart review – are replaced with quality assurance. At a minimum, physicians must meet with their NPs /PAs on a monthly basis with adjustments over time for experience.

- The bill allows flexibility in group practices that utilize multiple NPs and/or PAs.

This bill puts the physician firmly in the lead of the health care team with both the authority and responsibility to supervise. At the same time, it recognizes the importance of NPs and PAs as valuable members of the health care team.

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